

For Office Use Only:	
Final Deduction Date:	
//	

Date:		/
	CONTINUATION OF BENEFITS	
Name:		
Address:		
City/State/Zi	lip:	
Last Day of E	Employment:	
School Syster	m Name:	
	Please list below the voluntary benefits you wish to mak	e changes to:
	re resigning or retiring from your position with our school system, we need to v benefits. Please complete the information below and return this form eithe	
	I verify with my signature that I wish to continue the benefits	listed above.
	Signature:	
	Last 4 digits of SSN: Phone Number:	
	Email Address:	
	I verify with my signature that I DO NOT wish to continue the ben	efits listed above.
	Signature:	
	Last 4 digits of SSN: Phone Number:	
	Email Address:	

Please send completed form to:

easternregion@ffga.com Or Fax to: 910-792-1438

Or by Mail to: 3904 Oleander Dr. Ste 200, Wilmington, NC 28403